

Self-Mutilation and Self-Blame in Incest Victims

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A case is made for self-blame as the psychic link between children's experiences of incestuous sexual abuse and their self-mutilating behavior later in life. Representative case histories and the results of a small pilot study are presented to illustrate the author's theoretical formulation.

The act of self-mutilation in psychotherapy patients has been addressed by theorists, researchers, and clinicians.¹⁻⁵ There is little awareness, however, of the fact that incestuous sexual abuse characterized by physical brutality may lead to feelings of self-blame by the victim, culminating in acts of self-mutilation. The clinical literature tends to overlook the crucial connection between incestuous sexual abuse and self-mutilation; even when this connection is noted, it is buried in papers not directly focusing on the correlation. Hence, clinicians do not explore the possible links that result in such intensely destructive acts. Many young women who have been sexually abused as children use self-mutilation to express their emotional pain.⁶

Children are not born with the knowledge that they can assert power regarding their own bodies. Average child-rearing practices do not prepare children to resist when confronted with a sexually abusive situation, especially when the abuser is a family member. Yet, particularly if the child abuse occurs after age five, the child has often some awareness that the sexual contact was not in the realm of normal caretaking.

To make matters worse, society tends to blame the child victim regardless of the child's age. The child is often viewed as the seducer of the adult, and the incest is taken to be a sexual problem.⁷ It is more appropriate, according to Sgroi, to consider the problem in relation to the power dynamics between the adult and the child.⁸ When a child victim uses seductive behavior it is important to observe "the familial context of incest and how that context contributes to the alleged seductiveness of the child."⁷

Professionals have a tendency to continue to place some blame on the child. Henderson writes, "The daughters collude in the incest relationship and play an active and even initiating role in establishing the pattern."⁹ Lukianowicz also believes that the children are not innocent victims; "on the contrary, they were willing partners and often provocative seductresses"¹⁰

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(page 309). These clinical beliefs create the social and professional attitudes which then make disclosure of the incest more difficult, if not impossible, for the child.

X The sexually abused child may feel that she has caused the sexual activity to occur and, therefore, may feel responsible for the abusive behavior. If the child divulges the "secret" of the sexual activity, she may feel that she has betrayed and violated the supposedly trusting relationship she had with the abuser. The victim may also blame herself for the painful and confusing disruption experienced by the family after disclosure.¹¹⁻¹³ A child is developmentally unable to comprehend the nature of incest. The repudiation by others, religious constraints, and other societal factors cause the increase of negative feelings that are then directed inward, forming the nucleus for future self-destructive behaviors.¹⁴ The myriad self-destructive behaviors used by the victim act as the mechanism by which she copes with the legacy of emotional pain and the unconscious self-blame created by the incest trauma. (1)

Guilt, shame, a negative self-image, and feelings of betrayal are part of the inheritance of the sexually abused child.¹¹ Undermined self-confidence and negative societal responses are added to the child's fears. Self-blame generates feelings of self-hate and worthlessness. Furthermore, parental pressure limiting the child's relationships to the family sphere leaves her with poor social skills, thus compounding her feelings of helplessness.⁸ (2) These feelings permeate the child's perceptions of self and others.

Clearly, the victimized child is not to blame for the sexual abuse, but self-blame is a mental activity of a victim (either conscious or unconscious) which may also surface in dreams or in the need for self-destructive behavior. Nightmares reflecting the child's fear of the consequences of both the sexual abuse and its disclosure often plague the victim.⁸ Depression—often overt, sometimes more hidden—is commonly found in victims of sexual abuse. In addition to self-mutilation, suicide attempts, and other behaviors such as, sadness, withdrawal, fatigue, and symptoms of illness are all commonly exhibited reactions.⁸ When the abuse continues, feelings of shame, self-blame, rage, and self-hatred increase, along with deep ambivalence toward both parents. The child who does not disclose the abuse remains powerless; her anger and disappointment in others are directed inward, and her coping mechanism becomes a complex of self-destructive behaviors. (3)

The dynamics of self-blame have their origin in early stages of development. In relation to self-destructive behavior and self-blame, a distinction must be made between the conscious and unconscious components of self-blame. On a conscious level, self-blame could be defined through the victim's awareness of these issues, and each victim's experience of self-blame will vary. Unconscious self-blame has distinct developmental precursors that can be reactivated and intensified at any age. It is suggested that self-blame operating on the conscious level should be observed in relation to a

developmental framework that includes the earliest onset of feelings of guilt and shame.

The differentiation between shame and guilt continues to remain a controversial factor in the theoretical literature. In order to move beyond this complex issue and return to the topic of incest and its connection to self-mutilation, the following may sufficiently clarify this distinction: guilt arises out of conflict between the ego and the superego; shame arises out of the conflict between the ego and the ego ideal.¹⁵ Shame is the more profound affect because it develops at a more primitive level than guilt, and the psychological implications of shame may be more difficult to resolve and may result in self-mutilating behavior.

I have conducted a small pilot study which focuses on this topic in interviews with eleven women. The women interviewed were residing in Hartford, Connecticut, and Western Massachusetts. The sample was relatively heterogeneous and comprised two Black women, one Hispanic woman, and nine Caucasian women. The protocol used for the interview process was designed by Suzanne M. Sgroi, M.D.; Nicholas A. Groth, Ph.D.; Sister Marjorie Fallon, RSM; and me. Since the focus of this paper is on father-daughter incest and self-mutilation, data not relevant to these issues were eliminated.

The literature on self-mutilation describes people who mutilate themselves as being predominantly grouped in adolescence or young adulthood.⁵ This age group was the target population of this pilot study. Issues of confidentiality made it difficult to secure subjects under the age of fifteen (the age of the youngest subject in this study), and, therefore, the age limit was extended to thirty-three (the age of the oldest woman interviewed).

PILOT STUDY

For the purpose of this investigation, incest was defined as overt sexual contact such as masturbation, genital-oral penetration, and/or vaginal or anal intercourse between father and daughter or between father-figure and a girl under the age of eighteen. This study included only those women who were admittedly sexually abused and were involved at some point in their lives with counseling or support groups where the incest was acknowledged.

Self-mutilating behavior was highly prevalent among the women in this sample. Six of the eleven women mutilated themselves. This rate is high, considering the fact that this was a sample of convenience and that no attempt was made to seek a self-mutilating population. Still, because the sample was small and non-random, generalizations cannot be made. The prevalent behavior of self-mutilation, however, certainly suggests more than a casual association with incest.

In response to the inquiry about self-mutilation, three of the women said they had cut themselves deliberately one time. One woman said she had cut

herself twice deliberately and about fifteen times accidentally. The remaining two women had cut themselves deliberately and frequently with razor blades, knives, and pieces of glass. These two women also reported frequent incidents of deliberate self-burning. One woman, who said she had never injured herself deliberately, reported having had many car accidents and other accidents resulting in broken fingers, arms, nose, and legs. All eleven women said they were troubled by thoughts about suicide.

Four of the eleven women reported frequency of drug overdose. The findings showed that nine of the women interviewed had used street drugs extensively during some phase of their lives after the sexual abuse. Diet pills, sleeping pills, tranquilizers, and marijuana were among the drugs commonly used.

The victims were asked: "What thoughts go through your mind at times when you feel like injuring yourself?" Examples of thought processes can be found in the following cases:

Kelly: Sometimes I feel dead and hurting myself makes me feel more real; at other times it's punishment. Most often the physical pain eliminates the emotional pain. Often times, I just want to die and stop the emotional pain.

Elaine: Despair, there is no purpose to my living. I placed heavy judgment on myself. I'm bad because my parents didn't love me. There was self-blame and some rituals I had with blood. The self-mutilation was minimal by comparison to the mutilation perpetrated upon me by my parents.

Barbara: Why can't I be with my mother? Why did my real father have to die?

Nancy: When I was young, I'd go to sleep hoping I wouldn't wake up in the morning. I thought about different ways to do it, but mostly I hoped it would just happen.

One of the women who reported no incidents of injuries expressed the following:

★ *Mary:* I used to hallucinate hurting myself. I'd use sharp objects and cut out my eyes and my hair.

A clinical case report by Kwawer⁵ led him to postulate that "blood rituals repeatedly expressed primitive identifications with intrusive, controlling, and sadistic aspects of a psychotic mothering figure."⁵ In incestuous families, Kwawer's⁵ hypothesis can be extended to either parental figure. This finding is congruent with Elaine's and with Kelly's histories:

Case 1

Elaine is twenty-four years old. She remembers her mother as frequently going into delusional states during which she would manifest dramatic personality changes that included sadistic and controlling behaviors such as inflicting knife cuts around Elaine's breasts and vagina. Elaine was used as a sexual object by her mother, father, brother, and friends of her father. Elaine said that in addition to the cumulative

sexual abuse, her father would beat her and force her to take part in painful sexual acts in which he would insert an object, such as a tool or a gun barrel, into her anus or vagina and then force her to walk around the room with the foreign body still retained. Elaine's parents also participated in a sex ring which included the use of themselves and their children for purposes of pornography. The duration of Elaine's sexual abuse was approximately sixteen years. Elaine's leaving home at eighteen was the event which facilitated the cessation of incest.

Elaine first attempted suicide at age seven, when she took an overdose of drugs and was brought to the emergency room where she stayed overnight. Elaine said that she became more involved with mutilating herself from ages eleven through twenty-three.

An example of self-blame arising from incest that becomes so intolerable that it compels the victim to mutilate herself and become severely suicidal is illustrated in the case of Kelly:

Case 2

Kelly is twenty-five years old. She describes her mother as cold, vulnerable, anxious, and dependent. Kelly's father was a violent man, whom she describes as having no feelings for others. At age four, Kelly was first molested by her father; thereafter, the sexual abuse ceased, but was followed by an emergence of extreme physical abuse. At age fourteen, Kelly was raped by her father. The sexual abuse continued until Kelly was nineteen and was thrown out of the house.

Kelly's self-mutilating behavior began when she was seventeen years old. She inflicted severe cuts to her wrists, arms, and hands with sculpting knives and razor blades. Kelly's parents were told by a friend of the family about their daughter's cutting behavior, but her parents chose not to be involved with what was happening to Kelly psychologically and sexually. They did, however, send her to a psychiatrist for treatment. Since that time, Kelly has remained in psychiatric treatment with various therapists and has also been in eight psychiatric hospitals over the past five years.

For a while Kelly's parents came to the hospital for family sessions. Her parents would not allow her sister and brothers to attend the sessions even though it had been suggested by her therapist. In one of the family sessions, Kelly finally found the courage to confront her father. Her father denied the abuse and said, "You know, you hear stories like this where the daughter claims the father raped her, but then you find out that she either hallucinated the whole thing or just made it up to get attention." Kelly then turned to her mother and asked if she believed her. She turned her head away from Kelly and said, "I don't want to hear about it." That was the last family session her father attended. Several weeks after that her mother also stopped attending sessions. Shortly after this confrontation, Kelly's father became a Born Again Christian.

After the session in which Kelly confronted her parents with the incest experience and they denied the event, Kelly first externalized her rage by attempting to attack another patient. Shortly after, however, her rage was turned inward, and she regressed into a state of self-blame in which she became suicidal and mutilated herself.

Thoughts experienced by the victims prior to an episode of self-injury appear to be related to unresolved fears of abandonment and separation. In addition to the sexual trauma, the unresolved conflictual feelings presented by these women may also be seen as contributing factors to the development of self-blame and self-mutilating behavior.

Case 3

Barbara, now fifteen, had been sexually abused by her older brother and step-father for three years. At times, she would blame herself for the abuse and her subsequent placement in a foster home. Barbara had a history of self-mutilating behavior. When Barbara's therapist informed her that she was leaving the agency, Barbara threatened to cut herself and take the remaining medication she had at home.

All of the women reported sleep disturbances, and in most cases, their internal struggles were reflected in their dreams. Recurrent themes were rape, invasion, pursuit by men with guns, death of the self, and fear of the loss of the object. The women were asked if they had many bad dreams and what the themes were:

Leslie: Fear of losing my brother. That something was going to happen to my father who is in prison. How the past could have been different.

★ *Kelly:* I dream about running down a dark dead-end alley; my father is chasing me with a loaded gun. He shoots, hits me in the left shoulder, and I fall and turn around; then I see him pointing the gun at my head. I also have dreams about being in bed asleep and someone entering and raping me. The moonlight comes in and I see my father's face.

The manifest content of the dreams are indicative of the emotional pain and conflict-laden feelings common to the victim of sexual abuse. Both of the women whose dreams are presented above have mutilated themselves and abused drugs as a means to cope with their traumatic histories.

THE INCEST VICTIM AND THE ETIOLOGY OF SELF-MUTILATION

BPD

Young women who mutilate themselves and are subsequently hospitalized are often diagnosed as having borderline personality disorder. Simpson³ suggests that when the tension of sexual abuse becomes intolerable, a transitional state of depersonalization occurs. The victim may suddenly cut herself or resort to other forms of self-destructive behavior. Self-mutilation is used to terminate the defense mechanism of depersonalization. The act of self-mutilation "enables the patient to be aggressor and aggressed, actor and acted upon, punisher and punished"³ (p. 46). I would add, "the blamer and the blamed" as an underlying dynamic.

Kernberg¹⁶ suggests that it is the splitting phenomenon which is fundamentally related to the borderline organization and is the main source of ego

weakness that leads to selective lack of impulse control. According to Podvoll,² when hospitalized patients cease mutilating themselves, revelations by patients to their therapists will include, "masturbatory wishes, fellatio fantasies, or homoerotic thoughts"² (p. 216). What Kernberg¹⁶ and Podvoll² do not include or investigate is the possible occurrence of sexual abuse in childhood, which may have led to their patients' fantasies and then also to the perceived need for self-mutilating behavior.

In one recent study, Carroll et al. suggest that the childhood histories of self-mutilators often reveal that sexual activity with older members had taken place. They also noted that family prohibitions against the expression of anger may have led to other means of coping, such as self-mutilation.⁴ Green,¹⁴ in another study on self-destructive behavior in physically abused children, suggests that the abused child is often blamed for the inadequacies of her parents and consequently made a scapegoat. Because of her inability to comprehend this process, a child will blame herself; thus, Green states, "Stimulation afforded [her] during the abusive interaction might reinforce further pain-seeking behavior" (p. 58).¹⁴ The dynamics leading to self-destructive behaviors resulting from physical abuse, as proposed by Green, appear strikingly similar to those shown stemming from sexual abuse.

Farberow's¹⁷ formulations indicate a division between what he terms "indirect self-destructive behavior" and "direct self-destructive behavior." According to Farberow, direct self-destructive people often display affects such as depression, withdrawal, and apathy, or agitation. He adds that strong feelings of guilt, anger, and extreme anxiety might also be expressed. It is interesting to view these findings in connection with the incest victim in whom similar affective states have been noted.^{8,13}

There are also many similarities between symptoms that surface in the victim of sexual abuse (such as lack of trust, self-destructive behaviors, depression, splitting of good vs. bad feelings toward parental figures) and symptoms seen in many young women who show so-called borderline pathology. If the ego structure seems to be fixated in the early phases of development, it may be easier to determine a proper diagnosis that can provide insight for treatment. However, a true developmental diagnosis may take time. In addition, if the clinician does not inquire about the client's sexual history, the wrong diagnosis may be assumed. For example, the *DSM III* could include the diagnosis on Axis II dysthymic disorder secondary to early incest/sexual abuse.

Sgroi⁸ recognizes the importance of obtaining a comprehensive diagnostic assessment. In accordance with Sgroi, I would further suggest the use of multiple diagnosis and careful analysis of the client's ego structure before implementing treatment interventions. For young women who have suffered incest and who have practiced self-mutilation, it would be essential to

provide sufficient exploration into the nature of the abuse and the possible relationship between their past experiences and their present self-mutilating behavior.

DISCUSSION

This study indicates that there is a crucial connection between violent incest and self-mutilating behavior. As mentioned before, data and theoretical discussion about this connection are lacking. Although this study cannot claim statistical validity in establishing the connection between incest, self-blame, and self-mutilation, clearly it presents evidence to indicate that further research would be fruitful, such as the work begun by me and my colleagues.

Although there may be many components to self-blame, when self-mutilation occurs in an incest victim, it is important that the therapist examine the dynamics related to the incest and bring to light the residue of self-blame within the victim. When the victim shows signs of a history of self-mutilating behavior, it would be beneficial to ascertain the level of guilt or shame the victim is struggling with. In those cases where incest and self-mutilation exist, there is generally sufficient ego damage to necessitate long-term psychotherapy. An empathic therapist who is trained in treating sexual abuse could guide the client in rebuilding her shattered ego. Whenever a client enters therapy and self-mutilating behavior is found, the therapist must inquire about the client's history specifically with regard to familial physical and sexual abuse.

It is recommended that therapists work collectively to increase their awareness of the reality of incest and its horrors, and to seek ways to provide corrective and healing experiences for the victim.

The salient characteristics of the incest victim and the high incidence of self-mutilating behavior suggest a need for further studies in this area. Such research could help clinicians to determine the client's potential for change and to facilitate more effective methods of treatment.

SUMMARY

✱ Childhood experiences of physical or incestuous sexual abuse increase the potential for self-destructive activity. The unresolved feelings of the victim become manifest through somatic difficulties, sleep disturbances, bad dreams, and self-mutilating behavior. Women who showed the greatest difficulty with impulse control came from extremely pathological environments. Self-blame is the psychic link between the actual incest experience and the self-mutilating behavior that may occur much later in life and yet seem to have no conscious connection for the victim.

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